August 11, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2 03 1329 01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Doctor of Chiropractic. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

This worker was injured on ___ when he was at work and suffered the onset of pain in his right shoulder. He has undergone chiropractic care and rehabilitation since shortly after the injury. Records presented are a letter of medical necessity as well as 1 page of records indicating that the patient claims less pain with the use of a muscle stimulator. No testing or treatment records from the patient's treatment program are received from the carrier, the treating doctor or the requestor. There is a travel card type sheet that is presented from January 17, 2003 indicating a diagnosis of a rotator cuff syndrome with a fair prognosis, but this is on a form provided by the account manager of the requestor, not the treating doctor. It is more of a prescription form than an actual treatment record. A second prescription sheet is dated March 20, 2003 with similar a similar diagnosis. Records from ___ indicate that reviews found a lack of medical necessity for extended use of a muscle stimulator.

REQUESTED SERVICE

The carrier has denied the medical necessity of the purchase of a R54i Sequential Stimulator, a 4 channel combination muscle stimulator and interferential unit.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The requestor gave no indication as to why a muscle stimulator was being prescribed for unlimited use on a shoulder injury that is about 16 months old.

There is no indication from the requestor as to why this is medically necessary. In the opinion of the reviewer, such a stimulator could lead to accommodation with extensive use. This would render the modality largely ineffective. Also, this is a passive treatment and there is no indication that passive treatment would be medically necessary at this stage of the treatment program for this injured worker. I see no records of surgical intervention in recent months nor any indication that this is more than a shoulder sprain. Even if this is a chronic pain patient, there are no studies which indicate that passive treatment such as this would be effective on a patient with this condition. As a result, I am unable to find this treatment modality medically necessary.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 11th day of October 2003